

**UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WISCONSIN**

PLANNED PARENTHOOD OF
WISCONSIN, INC., et al.,

Plaintiffs,

v.

JOSHUA KAUL, Attorney General of the
State of Wisconsin, in his official capacity,
et al.,

Defendants.

CIVIL ACTION

Case No. 19-cv-38 (WMC)

EXPERT REPORT OF DANIEL GROSSMAN, M.D., F.A.C.O.G.

Pursuant to Federal Rule of Civil Procedure 26(a)(2)(B), DANIEL GROSSMAN, M.D., F.A.C.O.G., makes the following disclosures:

I. My Qualifications and Publications

1. I am a professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco (“UCSF”) and a board-certified obstetrician-gynecologist (“ob-gyn”) with over 20 years of clinical experience. I currently provide clinical services, including abortion services, at Zuckerberg San Francisco General Hospital. I am also a Fellow of the American College of Obstetricians and Gynecologists (“ACOG”), where I previously served as Vice Chair of the Committee on Practice Bulletins for Gynecology. I am currently Chair of the ACOG Committee on Health Care for Underserved Women. I am also a Fellow of the Society of Family Planning and a member of the American Public Health Association. Additionally, I serve as Director of Advancing New Standards in Reproductive Health (“ANSIRH”) at UCSF. ANSIRH conducts innovative, rigorous, multidisciplinary research

on complex issues related to people's sexual and reproductive lives. I am a Senior Advisor at Ibis Reproductive Health, a nonprofit research organization, and I am also a researcher with the Texas Policy Evaluation Project, which is based at the University of Texas at Austin. I am a liaison member of the Planned Parenthood National Medical Committee, and between 2012 and 2015, I provided clinical services with Planned Parenthood Northern California (formerly Planned Parenthood Shasta Pacific).

2. I have served as a medical expert in cases challenging medically unnecessary and targeted regulations of abortion providers, including in *Whole Woman's Health v. Lakey*, 46 F. Supp. 3d 673, 676 (W.D. Tex. 2014), *aff'd in part, vacated in part, rev'd in part sub nom. Whole Woman's Health v. Cole*, 790 F.3d 563 (5th Cir. 2015), *modified*, 790 F.3d 598 (5th Cir. 2015), *rev'd & remanded sub nom. Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016), in which two Texas restrictions on abortion access were held to be unconstitutional.

3. I earned a B.S. in Molecular Biophysics and Biochemistry from Yale University and an M.D. from Stanford University School of Medicine. I completed a residency in Obstetrics and Gynecology at UCSF.

4. My research interests include contraceptive and abortion access, and evaluating the impact of integrating reproductive health and HIV services. My research has been supported by grants from federal agencies and private foundations. I have published over 170 articles in peer-reviewed journals and co-authored several book chapters, and I am a member of the Editorial Board of the journal *Contraception*.

5. An updated and current version of my curriculum vitae ("CV"), which sets forth my experience and credentials more fully, is attached to this declaration as Exhibit A. My CV contains a complete list of the publications that I have authored or co-authored.

II. Statements of My Opinions and the Basis and Reasons for Them

6. I understand that Wis. Stat. § 940.15(5) and Wis. Admin. Code Med. § 11.03 prohibit anyone other than a physician from performing a medication or surgical abortion, and Wis. Stat. § 940.15(5) makes it a felony to perform an abortion in violation of the aforementioned restrictions. These laws effectively forbid advanced practice nurses (APNs), including nurse practitioners and certified nurse-midwives, from providing abortions, even when they are otherwise trained, qualified, and competent to do so.

7. I further understand that Wis. Stat. § 253.105(2)(a), in combination with Wis. Stat. § 253.10(3)(c)(1), requires the same physician who conducts a patient's prerequisite physical examination—which must be performed prior to a patient receiving certain state-mandated information and at least 24 hours before a medication abortion is provided—must be the same physician to prescribe the abortion-inducing medication after the 24 hours have elapsed.

8. I additionally understand that Wis. Stat. § 253.105(2)(b) requires the same physician who conducted the patient's prerequisite physical examination at least 24 hours before a medication abortion to be physically present in the room when the abortion-inducing medication is given to the patient. This also effectively bans medication abortion by telemedicine.

9. Moreover, I understand that the combination of the same-physician and physical-presence laws effectively requires that a patient seeking a medication abortion make two trips to one of four abortion providers in the state (or stay overnight), to have an in-person appointment with the same physician, at least 24 hours apart. I understand that no similar same-physician requirement exists for patients seeking a surgical abortion.

10. I submit this report based on my education, my clinical training, my experience as a practicing physician over the past 25 years, my attendance at professional conferences, my own

medical research, and my regular review of other medical research in my field. The literature considered in forming my opinions includes, but is not limited to, the sources cited in the footnotes of this report and in my curriculum vitae. All opinions stated herein are to a reasonable degree of professional certainty.

Abortion Is Common, Safe, and Effective

11. Abortion is one of the most common medical procedures in the United States. Approximately one in four women in this country will have an abortion by age 45 years.¹

12. Women seek abortions for a variety of medical, familial, economic, and personal reasons. Fifty-nine percent of women who seek abortions are mothers who have decided that they cannot parent another child at this time,² and 66% plan to have children when they are older (and, for example, financially able to provide necessities for them, and/or in a supportive relationship with a partner so their children will have two parents).³

13. Abortion is one of the safest procedures in contemporary medical practice. A recent analysis of abortion care in the United States performed by the National Academies of Sciences, Engineering, and Medicine (“NASEM” or “the National Academies”) concluded that abortion is extremely safe, involving minimal risks.⁴ Abortion complications are exceedingly rare:

¹ Rachel Jones & Jenna Jerman, *Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014*, 107 AM. J. PUB. HEALTH 1904, 1904 (2017).

² JENNA JERMAN, RACHEL K. JONES, & TSUYOSHI ONDA, GUTTMACHER INSTITUTE, CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008 7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf.

³ Stanley K. Henshaw & Kathryn Kost, *Abortion Patients in 1994-1995: Characteristics and Contraceptive Use*, 28 FAMILY PLANNING PERSPECTIVES 140, 142 (1996).

⁴ NAT’L ACADS. OF SCIS., ENG’G, AND MED. (NASEM), THE SAFETY AND QUALITY OF ABORTION CARE IN THE UNITED STATES 77 (2018) (“The clinical evidence makes clear that legal abortions in the United States—whether by medication, aspiration, D&E, or induction—are safe and effective.”).

nationwide, less than one-quarter of 1% (0.23%) of all abortion patients (all procedures and gestational ages) experience a complication that requires hospital admission, surgery, or blood transfusion.⁵

14. In contrast, carrying a pregnancy to term and delivering a baby is significantly riskier than abortion. The national risk of maternal mortality associated with live birth is approximately 14 times higher than that of induced abortion.⁶ Moreover, every pregnancy-related complication is more common among women having births than among those having abortions. As many as 10% of women who give birth are hospitalized for complications associated with pregnancy aside from hospitalization for delivery.⁷

15. Women of color, and Black women in particular, face heightened risks of maternal mortality and pregnancy-related complications.⁸

16. In the United States, abortion is generally performed by one of the following methods: medication abortion, aspiration abortion, and dilation and evacuation (“D&E”). I understand that only medication abortion and aspiration abortion are at issue in this case.

17. Medication abortion may be safely provided in an outpatient setting through 77 days (or 11 weeks, zero days) after the first day of the woman’s last menstrual period (LMP). It

⁵ Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 OBSTETRICS & GYNECOLOGY 175, 175 (2015).

⁶ Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 215 (2012).

⁷ ANNE ELIXHAUSER & LAUREN M. WIER, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, COMPLICATING CONDITIONS OF PREGNANCY AND CHILDBIRTH, HCUP Statistical Brief #113 2 (2008), <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf>; see also F. Carol Bruce et al., *Maternal Morbidity Rates in a Managed Care Population*, 111 OBSTETRICS & GYNECOLOGY 1089 (2011).

⁸ Emily E. Petersen et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017*, 68 MMWR MORBIDITY & MORTAL WEEKLY REPORT 423, 423 (2019).

involves terminating a pregnancy through a combination of two medications: mifepristone and misoprostol. Mifepristone works by blocking the hormone progesterone, which is necessary to maintain pregnancy. Misoprostol then causes the cervix to open and the uterus to contract and expel its contents, generally within hours, thereby completing the abortion. Medication abortion requires no anesthesia or sedation; women are screened for eligibility and contraindications, receive counseling, and are then provided with the medications.

18. The U.S. Food and Drug Administration (FDA) first approved mifepristone for sale in the United States in 2000. At that time, evidence showed that a particular regimen of mifepristone and misoprostol was safe and effective through 63 days LMP.⁹

19. Subsequent research showed that other regimens of mifepristone and misoprostol were safer and more effective, and could be used through 70 days LMP. In 2016, the FDA approved an updated label for Mifeprex (the brand name for mifepristone) based on this evidence.¹⁰ It sets forth the following evidence-based regimen for medication abortion: On day one, the patient takes 200 mg of mifepristone orally; 24–48 hours later, the patient takes 800 mcg of misoprostol buccally (in the cheek pouch); 7–14 days later, the patient follows up with a health care provider to confirm that the pregnancy has been terminated.¹¹ The Mifeprex label has not been further updated (which is not unusual), but further research now shows that this regimen of mifepristone and misoprostol is safe and effective through 77 days LMP.¹²

⁹ Eric A. Schaff, *Vaginal Misoprostol Administered 1, 2, or 3 Days After Mifepristone for Early Medical Abortion: A Randomized Trial*, 284 JAMA 1948, 1948 (2000).

¹⁰ FDA, MIFEPREX: HIGHLIGHTS OF PRESCRIBING INFORMATION (2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf.

¹¹ *Id.*

¹² The aforementioned research is yet unpublished. See also Nathalie Kapp et al., *Medical Abortion in the Late First Trimester: A Systematic Review*, 99 CONTRACEPTION 77, 77–86 (2019) (review of articles

20. Aspiration abortion, also referred to as suction curettage, entails the use of suction to empty the contents of the uterus. A hollow curette is inserted into the uterus. At the other end of the curette, a hand-held syringe or an electric device is applied to create suction and empty the uterus. The procedure time is typically less than ten minutes. This method can be used up to 14–16 weeks LMP, depending on the training of the provider.

21. Although aspiration abortion is commonly referred to as a form of surgical abortion, it does not entail making any incision in the patient's body. Generally, oral medications or a local anesthetic are used for pain management in connection with aspiration abortion, but in some cases, moderate or deep sedation, or rarely general anesthesia, may be used.

22. Aspiration is also used in cases of early pregnancy loss (*i.e.*, miscarriage) and incomplete medication abortion. Medications may also be used to evacuate the uterus in case of early pregnancy loss, and the most effective regimen involves the use of mifepristone followed by misoprostol.¹³

Safety and Effectiveness of Medication Abortion

23. Medication abortion is one of the safest treatments in contemporary medical practice. It does not require anesthesia or sedation. Major complications following medication abortion are very rare, and, as stated above, far rarer than those associated with pregnancy and childbirth.

24. Complications that may follow a medication abortion occur only after the patient has left the health center. Although complications following medication abortion are rare, the most

examining the success of medication abortion from greater than 63 days through 84 days LMP).

¹³ Courtney A. Schreiber et al., *Mifepristone Pretreatment for the Medical Management of Early Pregnancy Loss*, 378 NEW ENGLAND J. OF MED. 2161, 2161 (2018).

common are incomplete abortion and continuing pregnancy. Almost all complications associated with medication abortion can be handled in an outpatient setting on a non-emergency basis. In addition, incomplete abortion and continuing pregnancy are known outcomes of medication abortion, about which patients are counseled before choosing the treatment. Patients make an informed decision when choosing medication abortion, understanding that it is more likely they will have an incomplete abortion or ongoing pregnancy compared to choosing to have an aspiration abortion.

25. The FDA-approved Mifeprex label, which aggregates data from seven United States clinical trials totaling over 16,000 medication abortion patients—including a study I published in 2011—shows that 97.4% of medication abortion cases were successful using the current evidence-based regimen I describe above. Only 2.6% of patients had any surgical intervention, and as described below, that intervention was typically a non-urgent aspiration procedure similar to a surgical abortion or miscarriage management. The reasons for such intervention included ongoing pregnancy, medical necessity, persistent or heavy bleeding, incomplete expulsion, or patient request.¹⁴

26. Similarly, my research shows that medication abortion will fail or be incomplete in approximately 2.0% of cases.¹⁵ The risks of failed or incomplete abortion increase with gestational age. Of the small percentage of women having any complication from medication abortion, by far the most common is an incomplete abortion, which happens if some tissue is retained in the uterus, which can cause continued bleeding or spotting. Like other complications of medication abortion,

¹⁴ FDA, *supra* note 10, at 13 tbl. 3.

¹⁵ Daniel Grossman et al., *Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine*, 118 OBSTETRICS & GYNECOLOGY 296, 299 (2011).

this occurs after the patient has left the abortion facility, as any bleeding or spotting generally will not start until after the second medication, misoprostol, is taken 24–48 hours later at a location of the patient’s choosing (usually, their home). If the abortion is incomplete, the patient has the option to take a second dose of misoprostol in order to complete it, to have an aspiration procedure similar to surgical abortion or miscarriage management, or, in some cases, to wait for the tissue to pass.

27. An even smaller proportion of patients will have a continuing pregnancy. If the patient has a continuing pregnancy, they have the option to take a second dose of misoprostol (sometimes combined with a repeat dose of mifepristone) to complete the abortion, or to have an aspiration procedure.

28. Serious complications requiring urgent care are even rarer. My 2017 study, which was published after the FDA approved the updated label for Mifeprex, found that among over 19,000 medication abortion patients (in-person or via telemedicine), only 0.26% experienced clinically significant adverse events—defined as treatment given in an emergency department, hospital admission, surgery, blood transfusion, or death (although there were zero reported deaths or cases requiring surgery).¹⁶ This finding is in accord with other clinical studies. One large study found that the risk of major complications from medication abortions—defined as serious unexpected adverse events requiring hospital admission, surgery, or blood transfusion—was 0.31%.¹⁷ That study also found that only 0.87% of patients undergoing abortion presented at an emergency department within six weeks of the procedure with an abortion-related complaint and

¹⁶ Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided Through Telemedicine Compared With In Person*, 130 OBSTETRICS & GYNECOLOGY 778, 780 (2017).

¹⁷ Upadhyay et al., *supra* note 5, at 178 tbl. 3.

received a related diagnosis or treatment.¹⁸ Another large-scale study showed that only 0.16% of medication abortion patients experienced a significant complication (defined as hospital admission, blood transfusion, emergency department treatment, intravenous antibiotics administration, infection, or death), and only 0.06% experienced complications resulting in hospital admission.¹⁹

Safety and Effectiveness of Aspiration Abortion

29. Aspiration abortions rarely result in complications. In a retrospective analysis of California fee-for-service Medicaid claims data, the incidence of abortion-related complications following aspiration abortion, including both major and minor events, was 1.3%. These complications included hemorrhage, infection, surgical trauma such as uterine perforation, anesthesia complications, incomplete abortion, and continuing pregnancy (which is not actually a complication but rather a treatment failure).

30. Only 57 of almost 35,000 women (0.16%) were found to have experienced a major complication such as hospital admission, surgery, or blood transfusion following an aspiration abortion, and there were no patient deaths.²⁰

31. Aspiration abortion is highly effective with a very low risk of incomplete abortion or continuing pregnancy. In a study of almost 17,000 patients undergoing aspiration abortion up through nine weeks LMP, 99.8% had a complete abortion after the initial procedure.²¹

¹⁸ *Id.* at 175.

¹⁹ Kelly Cleland et al., *Significant Adverse Events and Outcomes After Medical Abortion*, 121 OBSTETRICS & GYNECOLOGY 166, 169 tbl. 2 (2013).

²⁰ Upadhyay et al., *supra* note 5, at 175.

²¹ Luu Doan Ireland et al., *Medical Compared with Surgical Abortion for Effective Pregnancy Termination in the First Trimester*, 126 OBSTETRICS & GYNECOLOGY 22, 22 (2015).

Wisconsin's Physician-Only Restriction

32. In my opinion, Wisconsin's laws prohibiting clinicians who are not physicians from providing abortions offer no health or safety benefits to abortion patients. Rather, these laws harm people seeking abortion care by limiting its availability.

33. "Advanced practice nurses" (APNs) are a category of registered nurses who meet advanced education, training, examination, and licensing requirements, and include certified nurse practitioners and certified nurse-midwives. Along with other non-physician medical professionals with advanced experience and training, *e.g.*, physician assistants, they are also referred to as "advanced practice clinicians" (APCs). In many states, APCs and APNs have authority to prescribe medications and provide a wide range of services. It is my understanding that in Wisconsin, APNs may prescribe medications independent of physicians if the APNs fulfill additional training and examination requirements, and work in a documented "collaborative relationship" with a physician (or dentist) (referred to hereinafter as "advance practice nurse prescribers" or "APNPs").²²

34. APCs currently provide abortion care in many states. According to the Guttmacher Institute, as of November 1, 2019, in 16 states APCs may legally provide medication abortion.²³ In six of these states, including California where I practice, APCs may also provide first-trimester aspiration abortion.²⁴ In addition, Illinois (included in the 16 aforementioned states in which APCs may legally provide medication abortion) and Maine (not included in those 16 aforementioned

²² Wis. Stat. § 441.16; Wis. Admin. Code N. §§ 8.02(2), 8.03, 8.06(1), 8.10(7).

²³ GUTTMACHER INSTITUTE, STATE POLICY UPDATES: MEDICATION ABORTION (2019), <https://www.guttmacher.org/state-policy/explore/medication-abortion> (last visited December 1, 2019).

²⁴ NASEM, *supra* note 4, at 117.

states) just recently amended their laws to eliminate blanket bans on APCs providing abortion care.²⁵

35. Research shows that APCs can safely and effectively provide both medication and aspiration abortion.²⁶ This research demonstrates that the effectiveness of abortion provided by APCs is similar to provision by physicians, and there is no evidence that complications are higher. For example, in a prospective observational study performed in California, outcomes were compared between 5,812 first-trimester aspiration abortions performed by physicians and 5,675 procedures performed by APCs.²⁷ Abortion complications were found to be clinically equivalent in the two groups.²⁸ Likewise, studies have found that APCs provide medication abortions as safely and effectively as physicians.²⁹ One 2014 study on the safety and efficacy of medication abortion found “the superior efficacy of nurse-midwife provision of early medical [termination of pregnancy] in healthy women, when compared with standard doctor provision.”³⁰

²⁵ 775 Ill. Comp. Stat. Ann. 55/1-25(a) (2019); 22 M.R.S.A. § 1596(1)(c) (2019).

²⁶ S. Barnard et al., *Doctors or Mid-Level Providers for Abortion*, 7 COCHRANE DATABASE OF SYSTEMATIC REVIEWS, Art. No. CD011242, 1 (2015); see also Eva Patil et al., *Aspiration Abortion with Immediate Intrauterine Device Insertion: Comparing Outcomes of Advanced Practice Clinicians and Physicians*, 61 J. OF MIDWIFERY & WOMEN’S HEALTH 325, 325 (2016); Shireen J. Jejeebhoy et al., *Can Nurses Perform Manual Vacuum Aspiration (MVA) as Safely and Effectively as Physicians? Evidence from India*, 84 CONTRACEPTION 615, 620 (2011).

²⁷ Tracy A. Weitz et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 AM. J. OF PUB. HEALTH 454, 454 (2013); see also NASEM, *supra* note 4, at 103–05, 118–19.

²⁸ *Id.*

²⁹ See Shireen J. Jejeebhoy et al., *Feasibility of Expanding the Medication Abortion Provider Base in India to Include Ayurvedic Physicians and Nurses*, 38 INT’L PERSPECTIVES ON SEXUAL & REPROD. HEALTH 133, 139 (2012); Claudia Diaz Olavarrieta et al., *Nurse Versus Physician-Provision of Early Medical Abortion in Mexico: A Randomized Controlled Non-Inferiority Trial*, 93 BULLETIN OF THE WORLD HEALTH ORG. 249, 249 (2015); I.K. Warriner et al., *Can Midlevel Health-Care Providers Administer Early Medical Abortion As Safely and Effectively As Doctors?*, 377 LANCET 1155, 1159–60 (2011).

³⁰ Helena Kopp Kallner et al., *The Efficacy, Safety and Acceptability of Medical Termination of*

36. Several professional organizations, including ACOG,³¹ the American Public Health Association,³² and the World Health Organization,³³ endorse APC provision of abortion care. After reviewing the relevant published literature, the National Academies concluded that “APCs can provide medication and aspiration abortions safely and effectively.”³⁴

37. When the FDA updated the labeling for Mifeprex (mifepristone 200 mg), it removed language specifying that the prescriber needed to be a physician; as such, any qualified clinician may provide medication abortion.³⁵

38. APCs and APNs typically provide comparable or more complex medical interventions than medication or aspiration abortion.

- a. For example, APNs perform endometrial biopsies and colposcopies, perform cryotherapy of the cervix to treat cervical dysplasia, and insert paracervical blocks. Each of these procedures is at least comparable to aspiration abortion in its technical requirements or risk of complications,

Pregnancy Provided By Standard Care by Doctors or By Nurse-Midwives: A Randomized Controlled Equivalence Trial, 122 BRIT. J. OBSTETRICS & GYNECOLOGY 510, 515 (2014).

³¹ Am. Coll. of Obstetricians & Gynecologists (ACOG), *Increasing Access to Abortion*, Committee Opinion No. 613, 124 OBSTETRICS & GYNECOLOGY 1060 (2014; reaff’d 2019), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co613.pdf>.

³² AM. PUB. HEALTH ASS’N (APHA), PROVISION OF ABORTION CARE BY ADVANCED NURSES AND PHYSICIANS ASSISTANTS, APHA Policy No. 20112 (2011), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants>.

³³ WORLD HEALTH ORG., HEALTH WORKER ROLES IN PROVIDING SAFE ABORTION CARE AND POST-ABORTION CONTRACEPTION 6–10 (2015), https://www.who.int/reproductivehealth/publications/unsafe_abortion/abortion-task-shifting/en/.

³⁴ NASEM, *supra* note 4, at 118–119.

³⁵ FDA, *supra* note 10.

and more complex than medication abortion in its technical requirements and risk of complications. Endometrial biopsy is similar to an aspiration procedure. Colposcopy requires skills of identifying signs of cervical dysplasia, performing biopsies, and managing bleeding with use of hemostatic agents. Insertion of a paracervical block, which is a component of an aspiration procedure, involves risk of lidocaine toxicity.

- b. If a patient has retained tissue in their uterus following a miscarriage or abortion, APNs may perform aspirations to evacuate the uterus to reduce risk of infection and other complications—a procedure identical to an aspiration abortion (and more complex than medication abortion), and when conducted following a miscarriage, one that can involve greater risk of complications and bleeding than an aspiration abortion. APNs may assist in placement of an intrauterine balloon (Foley balloon or Bakri balloon) for management of postpartum hemorrhage; this is of equivalent complexity and risk as an aspiration abortion.
- c. Certified nurse-midwife APNs manage labor and delivery, including induction of labor, delivery of a child and placenta, performance of episiotomies, repair of obstetrical lacerations and episiotomies, performance of circumcisions, and assistance with Caesarean deliveries—all substantially riskier than, and many of which more technically complex than, both medication and aspiration abortion.
- d. APNs administer sedation, including moderate IV sedation, in connection with aspiration abortions. Administration of sedation is indeed the riskiest

part of the aspiration abortion procedure and is riskier than medication abortion. Nurse anesthetist APNs provide general anesthesia, which is riskier than both medication and aspiration abortion.

- e. APNs also perform insertions and removals of intrauterine devices (“IUDs”) and contraceptive implants. Insertions and removals of IUDs involve risk of uterine perforation, which is not present in the context of medication abortion. Insertions and removals of IUDs and contraceptive implants both require a higher level of skill than prescription of medication abortion. In particular, many removals of IUDs without a visible string (which may require use of paracervical block, mechanical cervical dilation, ultrasound guidance, and/or use of instruments in the uterus, such as alligator forceps, IUD thread retriever, or IUD hook)—which are performed by APNs—are more complex than medication abortion and as complex as aspiration abortion. Further, certain difficult removal of contraceptive implants, which are performed by APNs, are more complex than medication abortion and as complex as aspiration abortion, as they require local anesthesia, knowledge of anatomy, and careful dissection, and carry a risk of nerve or vascular injury.
- f. I understand that Wisconsin law permits APNs to provide these medical interventions discussed in the sub-paragraphs above. I further understand that APNs at Planned Parenthood of Wisconsin perform many of these procedures.

39. Additionally, APNPs regularly prescribe medications for procedures that carry an

equivalent or higher level of risk than does medication abortion.

- a. For example, APNPs prescribe misoprostol in connection with management of postpartum hemorrhage, miscarriage management, management of incomplete abortion, difficult IUD insertion, and difficult IUD removal. Certified nurse-midwife APNPs may prescribe misoprostol in connection with induction of labor. Prescription of misoprostol in connection with management of incomplete abortion, management of postpartum hemorrhage, and miscarriage management involves a higher level of risk of bleeding than does prescription of medication abortion. Induction of labor is substantially riskier than both medication and aspiration abortion. And, as explained above, IUD insertions involve risk of uterine perforation which is not present in the context of medication abortion, and require greater skill than prescription of medication abortion. Difficult IUD removals, i.e., removals without a visible string, can be as complex as aspiration abortion.
- b. APNPs with the necessary U.S. Drug Enforcement Administration license to prescribe controlled substances may prescribe narcotics in connection with, *inter alia*, medication abortions, miscarriage management, and labor and delivery (certified nurse-midwife APNs). Some prescribe and/or administer sedation in connection with miscarriage management or aspiration abortions. Again, miscarriage management involves a higher level of risk of bleeding than does prescription of medication abortion. Inducing labor and delivering babies are substantially riskier than both medication and aspiration abortion. Aspiration abortion is more technically

complex than prescription of medication abortion, and administration of sedation is riskier and more technically complex than medication abortion.

- c. I understand that Wisconsin law permits APNPs to prescribe these medications discussed in the sub-paragraphs above, including in connection with these procedures discussed in the sub-paragraphs above. I further understand that APNPs at Planned Parenthood of Wisconsin prescribe certain of these medications in connection with these procedures.

40. For all of the above reasons, I believe that the physician-only requirement unnecessarily limits the provision of abortion by willing and capable providers.

Wisconsin's Same-Physician Restriction

41. In my expert opinion, Wisconsin's laws that require that the same physician who conducts the patient's prerequisite physical examination at least 24 hours before a medication abortion be the same physician who ultimately prescribes the abortion-inducing medication (at a second appointment) do not provide any health or safety benefits to patients. Rather, and particularly in combination with the related restriction that requires that the physician then be physically present when the abortion-inducing drug is given to the patient, these laws harm patients by limiting availability of, and thus access to, medication abortions.

42. I am unaware of any other context in which the medical professional who conducts an initial examination of a patient is legally or ethically required to be the one who ultimately prescribes a treatment or performs a subsequent procedure, even for medical care far riskier than abortion.

43. Rather, it is standard and ethical medical practice for a team of medical professionals to treat the same patient over a period of time. Each team member has a responsibility

to mark in the patient's chart any information that the rest of the medical team should know to carry out the treatment plan. To deny a patient needed medical care, simply because the specific health care provider who initiated the treatment plan is unavailable, contravenes both accepted practice and medical ethics.

44. As an ob-gyn, I find this restriction particularly absurd. Obstetricians regularly work in shifts, even to deliver babies, which is significantly riskier than the provision of medication abortion. During labor and delivery, it is common for one obstetrician to begin overseeing a woman's active labor in the hospital, only for a second obstetrician to take over and deliver the child, if and when the first provider's shift ends. To refuse to take over for the first provider would be unethical and medically unsound.

45. The ACOG Committee on Health Care for Underserved Women has issued a formal statement that laws requiring the same medical professional perform both in-person counseling and the later abortion are "medically unnecessary."³⁶ ACOG "opposes such requirements because they improperly regulate medical care and do not improve patient safety or quality of care."³⁷

46. In my clinical experience, oftentimes a patient seeking abortion services will interact with more than one medical professional. For example, one medical professional may administer a pregnancy test and provide counseling, while another may give the patient the actual medication, and yet another may conduct the follow-up appointment a week later to ensure the abortion is complete. The medical professional who ultimately prescribes a medication abortion

³⁶ ACOG, COMMITTEE OPINION NUMBER 613 at 3 (2014; reaff'd 2017), https://journals.lww.com/greenjournal/fulltext/2014/11000/Committee_Opinion_No__613___Increasing_Access_to.34.aspx.

³⁷ *Id.*

is routinely different from the medical professional who conducted the initial examination of the patient, with no adverse effect on the patient.

47. Additionally, in my clinical experience, it would be ludicrous to force patients to reschedule because the same medical professional who conducted their first examination fell ill or otherwise became unavailable to conduct the second appointment. Moreover, it would be unethical to force that patient to delay their treatment—which may mean being ineligible for medication abortion altogether if the patient will be past the gestational age limit—simply because of this restriction.

48. As stated above, these laws (and particularly in combination with the related Physical Presence Restriction, which requires that the prescribing professional then be physically present in the room when an abortion-inducing drug is given to the patient) only further limit the availability of abortion services, by requiring that patients obtain the second appointment with the exact same provider who examined them at the earlier appointment, and do not enhance the safety or effectiveness of medication abortion.

Wisconsin's Physical Presence Restriction and Telemedicine

49. I am familiar with Wisconsin's law requiring the prescribing medical professional be physically present in the room when an "abortion-inducing drug" is given to a patient, which serves no medical purpose and operates as a *de facto* ban on using telemedicine in the provision of medication abortion. In my opinion, this law offers no health or safety benefits to abortion patients but instead harms people seeking abortion care by limiting its availability.

50. I am unaware of any other context in which the medical professional who prescribes a medication is required to be physically present when the medication is given or dispensed to the patient, even for medical treatment far riskier than medication abortion, and medication far riskier

than mifepristone.

51. The lack of a medical justification for the Physical Presence Restriction is evident in light of the way that medication abortion works. As previously explained, medication abortion is a two-step process: First, the patient takes a dose of mifepristone to block the progesterone hormone, which is necessary to maintain pregnancy. The first dose of mifepristone does not pose risk of immediate, severe adverse reaction. Then, 24–48 hours later, the patient takes a dose of misoprostol, which causes the cervix to open and expel the contents of the uterus. The patient may take the dose of misoprostol at a location of their preference, typically their home. Any complications (themselves rare) would only start after the patient has left the abortion facility and usually after they have taken the dose of misoprostol, at home, 24–48 hours after mifepristone.

52. I understand that Wisconsin law does not require the physical presence of the prescribing professional when any other medication is given or dispensed to a patient, even medications that do pose a risk of serious side effects, such as chemotherapy drugs.

53. Indeed, I cannot conceive of a medical reason why the prescribing physician, who has consulted with the patient and prescribed mifepristone and misoprostol, would need to be physically present in the room when the drugs are given or dispensed to the patient. This requirement does not enhance the safety or effectiveness of the treatment. Instead, the Physical Presence Restriction (and in particular, in combination with Wisconsin's Same-Physician Restriction) harms patients by limiting the availability of medication abortion.

54. Specifically, in my expert opinion, the Physical Presence Restriction harms patients by operating as a *de facto* ban on the provision of medication abortion via telemedicine, without medical justification.

55. Telemedicine is the delivery of health care services at a distance through

information and communication technology.³⁸ Telemedicine has been used to expand the reach of medical professionals in many disciplines around the country and found to be safe and effective.³⁹ Telemedicine for abortion services has the potential to provide abortion services earlier in pregnancy and closer to a woman's home and to help overcome barriers to abortion access in the United States.

56. Telemedicine for medication abortion is as safe and as effective as in-person treatment.⁴⁰ The complication rate for medication abortion is exceedingly low (less than 0.5%), whether it is provided in-person or by telemedicine.⁴¹ In our 2011 Iowa study, we investigated the effectiveness and acceptability of telemedicine for medication abortion compared to in-person medication abortion, and we found that the success rates were very similar: 98.7% for telemedicine patients and 96.9% for in-person patients.⁴² No patient in this study required hospitalization.⁴³ In fact, the overall rate of adverse events in the study was less than 0.3%.⁴⁴ Importantly, we found that telemedicine and in-person patients had no significant difference in the occurrence of adverse events.⁴⁵

³⁸ Daniel Grossman et al., *Changes in Service Delivery Patterns After Introduction of Telemedicine Provision of Medical Abortion in Iowa*, 103 AM. J. OF PUB. HEALTH 73, 73 (2013).

³⁹ Grossman et al. (2011), *supra* note 15, at 300; *see also* Victoria A. Wade, *A Systematic Review of Economic Analyses of Telehealth Services Using Real Time Video Communication*, 10 BMC HEALTH SERVS. RESEARCH 233 (2010).

⁴⁰ Grossman et al. (2011), *supra* note 15, at 300; *see also* Wade, *supra* note 39, at 233.

⁴¹ Grossman et al. (2011), *supra* note 15, at 300; *see also* Wade, *supra* note 39, at 233.

⁴² Grossman et al. (2011), *supra* note 15, at 299.

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

57. In our 2017 Iowa study, we compared the safety of medication abortion between patients receiving services by telemedicine and those having an in-person visit at Planned Parenthood of the Heartland clinics in Iowa from July 1, 2008, to June 30, 2015.⁴⁶ In this 7-year study, 8,765 medication abortions were performed with telemedicine, and 10,405 received an in-person appointment.⁴⁷ We found that medication abortion patients rarely experienced clinically significant adverse events (only 0.26% of the 19,170 patients).⁴⁸ These adverse outcomes were uncommon with telemedicine (0.18% of telemedicine patients), and there were zero reported deaths or cases requiring surgery among any of the medication abortion patients.⁴⁹ Indeed, there was no significant difference in the prevalence of adverse events between telemedicine and in-person patients.⁵⁰

58. As the National Academies concluded, there is no medical need for medication abortion to be administered in the physical presence of a health care provider.⁵¹ Screening women for contraindications and eligibility, providing counseling, and dispensing medication can be done with equal safety regardless of whether the provider is physically present in the room with the patient. Additionally, in the rare occasions when complications do arise, it would not matter whether the patient obtained a medication abortion in-person or through telemedicine. This is so because any complications that do arise after medication abortion occur after the patient has left

⁴⁶ Grossman & Grindlay (2017), *supra* note 16, at 778.

⁴⁷ *Id.*

⁴⁸ *Id.* at 780.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ NASEM, *supra* note 4, at 79.

the clinic.

59. Additionally, the reported risks of medication abortion are low and similar in magnitude to the adverse effects of common prescriptions and over-the-counter medications.⁵² As the National Academies found, when taken together with the Iowa study's findings, it appears that providing medication abortion in specific facilities or with an in-person visit with the clinician is not necessary to ensure safety, as the risks are essentially the same as common pharmaceuticals routinely dispensed in pharmacies and taken at home.⁵³ A recent report issued by the FDA confirms the very low risk of death associated with medication abortion—a risk that is lower than the risks reported for penicillin, Tylenol, or Viagra.⁵⁴

60. Telemedicine for medication abortion has been used in Iowa since June 2008,⁵⁵ in Alaska since 2011,⁵⁶ Maine since 2016,⁵⁷ until recently by one clinic in Illinois since 2016,⁵⁸ and most recently in Washington, Hawaii, New York, and Oregon through the Gynuity TelAbortion

⁵² *Id.* at 58.

⁵³ *Id.*

⁵⁴ ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH (ANSIRH), ISSUE BRIEF: ANALYSIS OF MEDICATION ABORTION RISK AND THE FDA REPORT “MIFEPRISTONE U.S. POST-MARKETING ADVERSE EVENTS SUMMARY THROUGH 12/31/2018” 2 (2019), https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf.

⁵⁵ Grossman et al. (2013), *supra* note 38, at 73–78.

⁵⁶ Kate Grindlay & Daniel Grossman, *Telemedicine Provision of Medical Abortion in Alaska: Through the Provider's Lens*, 23 J. OF TELEMED. & TELECare 680, 680 (2016).

⁵⁷ Sarah Boden, *Maine Follows Iowa's Lead on Telemed Abortion*, IOWA PUB. RADIO (Feb. 29, 2016), <http://www.iowapublicradio.org/post/maine-follows-iowas-lead-telemed-abortion#stream/0>.

⁵⁸ Angie Leventis Lourgos, *Illinois Clinic Provides Abortions Via Telemedicine, Which Provides Wider Access But Is Prohibited in 19 States*, CHI. TRIB. (Jan. 19, 2018), <http://www.chicagotribune.com/lifestyles/health/ct-met-telemedicine-abortion-illinois-20171220-story.html>; Julie Spitzer, *How One Illinois Clinic Provides Abortions via Telemedicine*, BECKER'S HOSP. REV. (Jan. 19, 2018), <https://www.beckershospitalreview.com/telehealth/how-one-illinois-clinic-provides-abortion-via-telemedicine.html>.

Study.⁵⁹ Telemedicine is also being used in Utah to provide state-mandated, pre-abortion informed consent.⁶⁰ Providers have found it easy to integrate the new technology for telemedicine into their clinic operations, as it requires the same processes and clinic flow as an in-person visit.⁶¹ Providers using telemedicine report that their interactions with the patients are essentially the same as an in-person visit.⁶² Medication abortion through telemedicine is safe and effective, and acceptability is high among women who choose this model for treatment.⁶³ In fact, telemedicine patients are more likely than face-to-face patients to recommend medication abortion to a friend.⁶⁴

61. In a 2019 systematic review of evidence regarding telemedicine used for medication abortion, the authors found that the provision of medication abortion via telemedicine is safe, effective, and well-liked by both patients and providers.⁶⁵ The review found that clinical outcomes, including the rates of successful abortion, hospitalization, and blood transfusions were similar to those reported for the provision of medication abortion in person.⁶⁶ Another analysis of data from Alaska, Idaho, Nevada, and Washington that included 445 telemedicine patients and

⁵⁹ Elizabeth Raymond et al., *TelAbortion: Evaluation of a Direct to Patient Telemedicine Abortion Service in the United States*, 100 CONTRACEPTION 173, 174 (2019).

⁶⁰ See Sara Daniel et al., *Characteristics of Patients Using Telemedicine Compared with In-Person Visits for State-Mandated Informed Consent Before Abortion in Utah*, 99 CONTRACEPTION 316 (2019).

⁶¹ Grindlay & Grossman (2016), *supra* note 56, at 682.

⁶² *Id.* at 683.

⁶³ Grossman et al. (2011), *supra* note 15, at 300; see also Kate Grindlay et al., *Women's and Providers Experiences with Medical Abortion Provided Through Telemedicine: A Qualitative Study*, 23 WOMEN'S HEALTH ISSUES 117 (2013).

⁶⁴ Grossman et al. (2011), *supra* note 15, at 300.

⁶⁵ Daniel Grossman, *Telemedicine for Medical Abortion—Time to Move Towards Broad Implementation*, 126 BJOG: INT'L J. OBSTETRICS & GYNECOLOGY 1103, 1103 (May 10, 2019).

⁶⁶ Margit Endler et al., *Telemedicine for Medical Abortion: A Systematic Review*, 126 BJOG: INT'L JOURNAL OF OBSTETRICS & GYNECOLOGY 1094, 1098 (2019).

4,011 patients receiving medication abortion with an in-person visit confirmed previous findings documenting the safety and effectiveness of telemedicine provision of medication abortion.⁶⁷

62. Telemedicine furthers public health because it improves access to early medication abortion in underserved areas. The number of abortion providers has declined over the last three decades in the United States, resulting in greater distances and higher costs for some patients to obtain treatment.⁶⁸ I understand that in Wisconsin, there are only four abortion clinics, located in three of Wisconsin's 72 counties.

63. Telemedicine improves access for disproportionately-affected poor women and those living in rural and underserved areas who are not readily able to travel.⁶⁹ In 2017, in the United States, 89% of counties lacked an abortion provider and 38% of women of reproductive age lived in those counties and would have to travel to receive abortion care.⁷⁰ In Wisconsin, 97% of counties have no abortion provider, and 70% of women live in one of those counties.⁷¹

64. Women in rural areas are disproportionately impacted. In fact, ACOG has expressed ongoing concern over the lack of medical services available to women in rural communities, and has asked ob-gyns to “[f]oster and participate in efforts to utilize effective telemedicine technologies . . . to expand and improve services for rural women.”⁷² According to

⁶⁷ Julia Kohn et al., *Medication Abortion Provided Through Telemedicine in Four U.S. States*, 134 OBSTETRICS & GYNECOLOGY 343 (2019).

⁶⁸ Grindlay, *supra* note 63, at 117–22.

⁶⁹ *Id.*

⁷⁰ RACHEL K. JONES ET AL., GUTTMACHER INSTITUTE, ABORTION INCIDENCE AND SERVICE AVAILABILITY IN THE UNITED STATES (2017), <https://www.guttmacher.org/report/abortion-incidence-service-availability-us-2017>.

⁷¹ GUTTMACHER INSTITUTE, STATE FACTS ABOUT ABORTION: WISCONSIN (2019), <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-wisconsin>.

⁷² ACOG, *Health Disparities in Rural Women*, Committee Opinion No. 586, 123 OBSTETRICS &

the 2010 census, 29.8% of Wisconsin's population is rural.⁷³

65. Telemedicine facilitates a patient-centered approach to care, enabling women to be seen sooner, with greater choice in abortion procedure type, and to be closer to their home.⁷⁴ For example, as a result of the institution of telemedicine in Alaska, providers were able to schedule additional appointments that better met patients' needs and in turn allowed patients to be seen at earlier gestational ages.⁷⁵ Telemedicine also expands access to abortion services by allowing clinics to provide more appointments with shorter wait times.⁷⁶ In contrast, before telemedicine, clinics in areas without or with few abortion providers had to transport providers to the clinic. In Alaska, the need to transport providers limited the clinic's ability to offer abortion services to only once or twice a month.⁷⁷ This limitation increased the wait time for patients to receive an abortion procedure, at times pushing them beyond the gestational limit for medication abortions.⁷⁸

66. Between October 2009 and February 2010, we conducted a study in Iowa, in which we performed in-depth interviews with women receiving telemedicine and clinic staff involved in providing medication abortion through telemedicine.⁷⁹ The study showed that women opted for

GYNECOLOGY 384 (2014; reaff'd 2018), <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co586.pdf>.

⁷³ U.S. CENSUS BUREAU, WISCONSIN: 2010 POPULATION AND HOUSING UNIT COUNTS (2012), <https://www.census.gov/prod/cen2010/cph-2-51.pdf>.

⁷⁴ Grossman et al. (2011), *supra* note 15, at 300.

⁷⁵ Grindlay & Grossman (2016), *supra* note 56, at 681–82.

⁷⁶ *Id.*; see also Grindlay, *supra* note 63, at 117–122.

⁷⁷ Grindlay & Grossman (2016), *supra* note 56, at 681.

⁷⁸ *Id.*

⁷⁹ Grindlay, *supra* note 63, at 118.

the telemedicine visit because of the close proximity, the reduced amount of time they had to take off from work or school, the lower costs associated with travel, and because they did not have to explain the reason for traveling to a more distant location.⁸⁰

67. In the same study, clinic staff cited numerous benefits to introducing telemedicine in their practice: ability by providers to see more patients; greater efficiency of resources, with women and providers no longer having to travel long distances; and fewer delays related to travel in severe weather.⁸¹ The greatest perceived impact in the study was the enhanced access for their patients.⁸²

68. We conducted another study in Iowa that assessed the effect of a telemedicine model providing medication abortion on service provided in Iowa clinics.⁸³ In Iowa, abortion access for women in more remote parts of the state increased with telemedicine.⁸⁴ Women living farther than 50 miles from the nearest clinic offering surgical abortion were more likely to obtain an abortion after the introduction of telemedicine in Iowa.⁸⁵ Telemedicine improved women's access to abortion care by expanding the number of clinics able to provide medication abortion and benefited patients by reducing travel distance.⁸⁶

69. The same study suggests that women had a 46% greater likelihood of having an

⁸⁰ *Id.* at 118–19.

⁸¹ *Id.* at 120.

⁸² *Id.* at 120–21.

⁸³ Grossman et al. (2013), *supra* note 38.

⁸⁴ *Id.* at 75.

⁸⁵ *Id.*

⁸⁶ *Id.* at 76.

abortion at or before 13 weeks of gestation when obtaining abortion services after the introduction of telemedicine.⁸⁷ Because patients often do not become aware that they are pregnant until about five weeks LMP or later, many patients struggle to access care within the short window in which medication abortion is available. By providing more scheduling options and locations closer to patients' homes, telemedicine allows them to access abortion services earlier in their pregnancies. As explained, the earlier an abortion is performed, the safer it is for the patient.⁸⁸ Thus, access to early abortion care benefits the public health, as reducing second trimester abortions helps to reduce the rare health risks associated with later abortions.

70. Health care providers use telemedicine to provide treatment, including the prescription of medications, that presents equivalent or greater risk to the patient than does medication abortion. For example, stroke specialists at UW Hospital evaluate patients via telemedicine and remotely prescribe a drug called tPA, which is used to treat thrombotic stroke but also presents a risk of bleeding.⁸⁹ It is my understanding that Wisconsin law permits such other treatments to be provided by telemedicine, including the issuance of prescriptions.⁹⁰

71. I understand from Plaintiffs' counsel that Planned Parenthood of Wisconsin has used telemedicine since 2009. I understand from Plaintiffs' counsel that the clinics currently employ telemedicine to provide health services including birth control prescription, including emergency contraception; urinary tract infection treatment; ordering sexually transmitted infection

⁸⁷ *Id.* at 75.

⁸⁸ Raymond & Grimes, *supra* note 6, at 1272.

⁸⁹ See David Wahlberg, *Technology Can Aid Health Issues in Rural Areas*, WIS. ST. J. (Dec. 26, 2010), http://host.madison.com/wsj/special-section/rural_health/technology-can-aid-health-issues-in-rural-areas/article_ed68add8-0de8-11e0-a644-001cc4c002e0.html.

⁹⁰ WIS. ADMIN. CODE MED. § 24-07.

testing and treatment; and assessment for IUD and/or contraceptive implant. I have been informed that APNPs also prescribe medications via telemedicine at Planned Parenthood of Wisconsin.

72. Again, there is no medical justification to requiring the prescribing medical professional to be physically present when the mifepristone and misoprostol are given to the patient, as the prescribing professional's physical presence at that time would not enhance the safety or effectiveness of the treatment.

Wisconsin's Abortion Restrictions Harm Patients

73. Enforcement of the laws discussed in this report harm people seeking abortion care in numerous ways. These harms include, but are not limited to delayed access to abortion; inability to access medication abortion; and being forced to carry an unwanted pregnancy to term. With these come attendant risks such as increased risk of intimate partner violence. As an ob-gyn, I have seen how unnecessary delays in access to abortion care cause my patients medical harm.

74. I understand that the only clinic outside Madison and Milwaukee—Planned Parenthood of Wisconsin's Sheboygan clinic—only offers medication abortions, and only offers them six days per month. As a result, many Wisconsin women must travel long distances to obtain an abortion.

75. Increases in distances traveled mean not only that patients must drive farther to access safe, legal, early abortion (or, if they lack access to a car, must take public transportation), but also must bear the increased financial, logistical, and psychological costs of reaching the nearest abortion provider. This includes making arrangements for additional child care, missed work, and other obligations; making arrangements for additional travel; and securing additional

funds.⁹¹ These logistical barriers result in delays in seeking care.⁹² Indeed, in one study of 1,209 abortion patients, among women who said they would have preferred to have had their abortions earlier, 56% of first-trimester patients reported they were delayed because it took a long time to make arrangements, including 23% who said they needed time to raise money to have the abortion and 6% who said they could not find a place to have an abortion near where they lived and so had to arrange for transportation.⁹³

76. Although abortion is one of the safest procedures in contemporary medicine, the risk of complications (as well as the cost of the procedure) increases as the pregnancy advances. And medication abortion is unavailable after 11 weeks' gestation. In a study I published in 2014, we found that, as a result of the number of abortion providers in Texas dropping from 41 to 22, there was a statistically significant increase in the proportion of abortions that occurred in the second trimester, suggesting restrictions on abortion access delayed abortions from the first into the second trimester.⁹⁴ We recently confirmed this finding in a more detailed analysis of abortion statistics from Texas.⁹⁵

⁹¹ See Liza Fuentes et al., *Women's Experiences Seeking Abortion Care Shortly After the Closure of Clinics Due to a Restrictive Law in Texas*, 93 CONTRACEPTION 292, 292–297 (2016).

⁹² See Sarah E. Baum et al., *Women's Experience Obtaining Abortion Care in Texas After Implementation of Restrictive Abortion Laws: A Qualitative Study*, 11 PLOS ONE no. 10, 2016, 5–14 (observing burdens women faced due to increased travel distances, including delay, due to Texas abortion restrictions, including among women who strongly preferred medication abortion and women who obtained a surgical abortion although they preferred medication).

⁹³ Lawrence B. Finer, *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 335 tbl. 1 (2006).

⁹⁴ Daniel Grossman et al., *Change in Abortion Services After Implementation of a Restrictive law in Texas*, 90 CONTRACEPTION 496, 499–500 (2014).

⁹⁵ Kari White et al., *Change in Second-Trimester Abortion After Implementation of a Restrictive State Law*, 133 OBSTETRICS & GYNECOLOGY 771, 771 (2019).

77. These barriers, and further delay, have negative effects on patients' mental health.⁹⁶ In addition to the emotional distress of being pregnant against one's will, some patients must conceal their pregnancies from abusive or controlling partners or family members. Others may fear that they will miss the window to have a medication abortion, or miss the window to have an abortion altogether, and be forced to carry an unwanted pregnancy to term. As a result, delays themselves cause many patients significant and unnecessary emotional distress.

78. Moreover, many individuals seeking an abortion face significant personal, social, and financial obstacles. Most abortion patients live on incomes below 200% of the federal poverty level.⁹⁷ For these patients in particular, it is a struggle to pull together the resources to take time off from work and arrange transportation to obtain an abortion. One study from Arizona, before that state's mandatory delay law went into effect, found that "the majority of women seeking abortion care had to forgo or delay food, rent, childcare, or another important cost to finance their abortion."⁹⁸ Furthermore, women with lower incomes are more likely to have later abortions.⁹⁹ Delaying an abortion until the second trimester increases the burdens of raising money for the procedure and making travel arrangements to a provider who offers that service.¹⁰⁰

⁹⁶ Jenna Jerman, *Barriers to Abortion Care and Their Consequences for Patients Traveling for Services: Qualitative Findings from Two States*, 49 PERSPS. ON SEXUAL & REPRO. HEALTH 95, 98 (2017).

⁹⁷ JERMAN, JONES, & ONDA, GUTTMACHER INSTITUTE, *supra* note 2 ("75% of abortion patients are low income, having family incomes of less than 200% of the federal poverty level.").

⁹⁸ Deborah Karasek, Sarah C.M. Roberts, & Tracy A. Weitz, *Abortion Patients' Experience and Perceptions of Waiting Periods: Survey Evidence Vefore Arizona's Two-Visit 24-hour Mandatory Waiting Period Law*, 26 WOMEN'S HEALTH ISSUES 60, 64 (2016) (31% reported compromised confidentiality because they had to tell someone they did not want to tell).

⁹⁹ Lawrence B. Finer et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 CONTRACEPTION 334, 339 fig. 2 (2006).

¹⁰⁰ *Id.* at 335 tbl. 1 (reporting that 67% of second-trimester patients said it took a long time to make arrangements; 36% said they were delayed because they needed time to raise money, 18% said they were

79. The majority of individuals seeking an abortion are already parents, and many have multiple children.¹⁰¹ Therefore, they need to organize and/or pay for additional childcare when they have health care visits. These patients may have inflexible work schedules and must work within narrow time constraints when arranging health care appointments.

80. Still others must conceal these arrangements from abusive or controlling partners or family members.¹⁰² According to the U.S. Centers for Disease Control and Prevention, 48% of Wisconsin women experience psychological aggression from an intimate partner in their lifetime, which amounts to approximately 1,063,000 women.¹⁰³ Psychological aggression includes name calling, insulting or humiliating an intimate partner, and behaviors that are intended to monitor and control or threaten an intimate partner.¹⁰⁴ Women who are forced to carry an unwanted pregnancy to term are more likely to continue having sustained contact with an abusive partner than women who have obtained an abortion.¹⁰⁵

81. Further, patients who are delayed past 11 weeks LMP are unable to access

worried about the cost, 16% said they did not know where to get an abortion, and 9% said they had to arrange for transportation).

¹⁰¹ See also RACHEL K. JONES, LAWRENCE B. FINER, & SUSHEELA SINGH, GUTTMACHER INSTITUTE, CHARACTERISTICS OF U.S. ABORTION PATIENTS 8 (2008), https://www.guttmacher.org/sites/default/files/report_pdf/us-abortion-patients.pdf (61% of abortion patients surveyed already had children, and 34% had two or more).

¹⁰² See ACOG, *supra* note 31.

¹⁰³ SHARON G. SMITH ET AL., U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY, 2010-2012 STATE REPORT 134-35, tbl. 5.9 (2017), <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>.

¹⁰⁴ See *id.* at 134-35, tbl. 5.9.

¹⁰⁵ Sarah C.M. Roberts et al., *Risk of Violence From The Man Involved in the Pregnancy after Receiving or Being Denied an Abortion*, 12 BMC MEDICINE 144, 144 (2014); Jane Mauldon et al., *Effect of Abortion vs. Carrying to Term on a Woman's Relationship with the Man Involved in the Pregnancy*, 47 PERSPECTIVES SEXUAL & REPRODUCTIVE HEALTH 11, 11 (2014).

medication abortion. Many patients prefer medication abortion because they can complete the process in the privacy of their homes, with the company of loved ones, and at a time of their choosing. Some choose medication abortion because they fear a procedure involving surgical instruments. Victims of rape, or those who have experienced sexual abuse or molestation, may choose medication abortion to feel more in control of the experience and to avoid trauma from having instruments placed in their vagina.

82. Recent statistics estimate that nearly one-fifth of all women in the United States have been raped at some point in their lives.¹⁰⁶ Over 80% of rapes are committed by someone known to the victim (*e.g.*, an intimate partner, family member, or acquaintance), and the perpetrator is a current or former intimate partner in nearly two-thirds of rapes.¹⁰⁷ Indeed, studies demonstrate that 10% to 14% of married women experience marital rape, and 40% to 50% of intimate-partner violence victims have experienced forced sex by an intimate partner.¹⁰⁸

83. For other women, there are medical reasons why medication abortion is better for them than surgical abortion. Some women have medical conditions that make medication abortion

¹⁰⁶MICHELE C. BLACK ET AL., NAT'L CTR. FOR INJURY PREVENTION & CONTROL, CTRS. FOR DISEASE CONTROL & PREVENTION, THE NATIONAL INTIMATE PARTNER AND SEXUAL VIOLENCE SURVEY (NISVS): 2010 SUMMARY REPORT 18 (2011); *see also* Junda Woo et al., *Abortion Disclosure and the Association with Domestic Violence*, 105 OBSTETRICS & GYNECOLOGY 1329, 1331 (2005) (finding that for women seeking abortion in study, 13.8% reported significant abuse within the past years); *id.* at 1329 (citing other studies of abortion patients finding abuse rates of 14–22% within the year and cumulative lifetime rates of 27–31%).

¹⁰⁷PATRICIA TJADEN & NANCY THOENNES, NAT'L INST. FOR JUSTICE, CTRS. FOR DISEASE CONTROL & PREVENTION, FULL REPORT OF THE PREVALENCE, INCIDENCE, AND CONSEQUENCES OF VIOLENCE AGAINST WOMEN 35, 43 (2000).

¹⁰⁸Elaine K. Martin et al., *A Review of Marital Rape*, 12 AGGRESSION & BEHAVIOR 329, 329 (2007). Intimate-partner violence includes birth-control sabotage, which occurs when a woman's partner attempts to obstruct her use of contraception by, for example, confiscating her birth control pills. One study reports that 19% of women at family planning clinics have experienced coercion from male partners to become pregnant, and 15% have experienced birth-control sabotage. Elizabeth Miller et al., *Pregnancy Coercion, Intimate Partner Violence, and Unintended Pregnancy*, 81 CONTRACEPTION 316, 316 (2010).

a significantly safer option, as it has a lower risk of both complications and failure than surgical abortion. My own research shows that most women who choose medication abortion have a strong preference for this method.¹⁰⁹

84. The relative risks from abortion increase when the pregnancy is further along, notwithstanding the procedure's high degree of safety in the absolute. Thus, delaying abortions and imposing significant obstacles on patients seeking abortion care raises the risk of complications.¹¹⁰ Additionally, later abortion is more expensive, is offered at fewer locations, and there are fewer providers.¹¹¹

85. When legal abortion is unavailable or difficult to access, some women turn to illegal, and potentially unsafe, methods to terminate unwanted pregnancies.¹¹² Other women, deprived of access to legal abortion, forgo the abortions they would have obtained if they could have and, instead, carry unwanted pregnancies to term. These women are exposed to increased risks of death and major complications from childbirth,¹¹³ and they and their newborns are at risk of negative health consequences, including reduced use of prenatal care, lower breastfeeding rates, and poor maternal and neonatal outcomes.¹¹⁴ These risks are even higher for women living in rural

¹⁰⁹ See Grossman et al., *supra* note 15, at 300 (finding 71% of study participants said they strongly preferred medication abortion).

¹¹⁰ Suzanne Zane, *Abortion-Related Morality in the United States: 1998-2010*, 126 OBSTETRICS & GYNECOLOGY 258, 258 (2015)..

¹¹¹ Rachel K. Jones et al., *Differences in Abortion Service Delivery in Hostile, Middle-Ground, and Supportive States in 2014*, 28 WOMEN'S HEALTH ISSUES 212, 216 (2018).

¹¹² Daniel Grossman et al., *The Public Health Threat of Anti-Abortion Legislation*, 89 CONTRACEPTION 73, 73 (2014); TEXAS POLICY EVALUATION PROJECT, RESEARCH BRIEF: TEXAS WOMEN'S EXPERIENCES ATTEMPTING SELF-INDUCED ABORTION IN THE FACE OF DWINDLING OPTIONS (2014), https://liberalarts.utexas.edu/txpep/_files/pdf/TxPEP-Research-Brief-WomensExperiences.pdf.

¹¹³ Raymond & Grimes, *supra* note 6, at 1272.

¹¹⁴ Anshu P. Mohllajee et al., *Pregnancy Intention and Its Relationship to Birth and Maternal*

and outlying areas, where there are fewer medical providers.¹¹⁵ Women forced to carry an unwanted pregnancy to term also may find it harder to bring themselves and their family out of poverty.¹¹⁶ As compared to women who obtained an abortion, women who wanted but could not access an abortion are more likely to be marginally employed, unemployed, or enrolled in public safety net programs.¹¹⁷ This economic insecurity could last years.¹¹⁸ And women who are victims of partner violence will, in many cases, face increased difficulty escaping that relationship (because of new financial, emotional, and legal ties with that partner).¹¹⁹

86. It is important to consider abortion restrictions in this context: access to abortion is important to public health.

III. Exhibits Used To Summarize or Support My Opinions

87. I have not used any exhibits to support my opinions, but I reserve the right to create demonstrative exhibits that summarize my opinions for use at trial.

Outcomes, 109 OBSTETRICS & GYNECOLOGY 678, 678 (2007); Jessica D. Gipson et al., *The Effects of Unintended Pregnancy on Infant, Child, and Parental Health: A Review of the Literature*, 39 STUDIES IN FAMILY PLANNING 18, 24–27 (2008).

¹¹⁵ Diana Greene Foster et al., *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. OF PUB. HEALTH 407, 407–413 (2018).

¹¹⁶ *Id.*; see also Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC WOMEN'S HEALTH, no. 102, 2015, at 1; Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. PEDIATRICS 183 (2019); Diana Greene Foster et al., *Comparison of Health, Development, Maternal Bonding, and Poverty Among Children Born After Denial of Abortion vs After Pregnancies Subsequent to an Abortion*, 172 JAMA PEDIATRICS 1053 (2018).

¹¹⁷ Foster et al., *supra* note 115, at 409–413.

¹¹⁸ *Id.* at 407, 409–413.

¹¹⁹ Roberts et al., *supra* note 105.

IV. Cases in Which I Have Testified as an Expert During the Past Four Years

88. During the past four years, I have testified as an expert at trial or by deposition in the following cases:

Planned Parenthood of the Heartland v. Branstad ex rel. Iowa, No. EQCE081503 (D. Ct. Iowa, Polk Cnty., 2017);

Comprehensive Health of Planned Parenthood Great Plains v. Williams, No. 17-4207-cv-c-bp (W.D. Mo. 2018);

Trust Women Found. Inc. v. Bennett, No. 2019-cv-000060 (D. Ct. Kan., Shawnee Cnty., 2019);

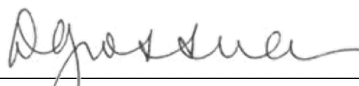
Whole Woman's Health All. v. Hill, No. 1:18-cv-1904-SBE-MJD (S.D. Ind. 2019);

Reproductive Health Servs. of Planned Parenthood of the St. Louis Region v. Mo. Dep't of Health & Senior Servs., No. 19-0879 (Mo. Admin. Hr'g Comm'n 2019).

V. Compensation

89. In addition to expenses that I incur, I am being compensated \$200 per hour for work performed on this case.

Dated: December 6, 2019



Daniel Grossman, MD, FACOG

Exhibit A

November 20, 2019

DANIEL A. GROSSMAN, M. D., F. A. C. O. G.

Advancing New Standards in Reproductive Health, UCSF
 1330 Broadway, Suite 1100
 Oakland, CA 94612

Current position

Professor, Department of Obstetrics, Gynecology and Reproductive
 Sciences at the University of California, San Francisco
 Director, Advancing New Standards in Reproductive Health
 (ANSIRH)

Education

Sept. 1985-May 1989	Yale University-Molecular Biophysics and Biochemistry	B.S., 1989
Sept. 1989-June 1994	Stanford University School of Medicine	M.D., 1994
June 1994-June 1998	Resident and Administrative Chief Resident, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco	

Licenses/Certification

1996-Present	California medical licensure (A60282)
2001-Present	Board-certified, American Board of Obstetrics and Gynecology

Principal positions held

Aug. 1998-Feb. 2003	Physician, St. Luke's Women's Center, San Francisco, CA
Aug. 2005-2012	
May 2003-Aug. 2005	Health Specialist, The Population Council Regional Office for Latin America and the Caribbean, Mexico City
Aug. 2005-Aug. 2015	Senior Associate (through June 2012), Vice President for Research (starting July 2012), Ibis Reproductive Health
Sept. 2015-Present	Professor, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
Sept. 2015-Present	Director, Advancing New Standards in Reproductive Health (ANSIRH)

Other positions held concurrently

Aug. 1998-Feb. 2003	Director of Medical Student Education, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-Feb. 2003	Vice Chair, Department of Obstetrics and Gynecology, St. Luke's Hospital
Aug. 1998-2015	Assistant Clinical Professor, Bixby Center for Global Reproductive Health, Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco
2012-2015	Contract physician, Planned Parenthood Shasta Pacific
Aug. 2015-Present	Senior Advisor, Ibis Reproductive Health

Honors and awards

- 1988 Howard W. Hilgendorf Jr. Fellowship, Yale University
- 1988 Robin Berlin Memorial Prize, Yale University
- 1989 Magna cum laude, Yale University
- 1990 Medical Scholars Award, Stanford University
- 1990 Peter Emge Traveling Fellowship, Stanford University
- 1991-1992 Foreign Language and Area Studies Fellowship, Stanford University
- 1994 Dean's Award for Research in Infectious Diseases, Stanford University
- 2007 Ortho Outstanding Researcher Award, Association of Reproductive Health Professionals
- 2009 Visionary Partner Award, Pacific Institute for Women's Health
- 2010 Scientific Paper Award, National Abortion Federation
- 2013 Gerbode Professional Development Fellowship
- 2013 Abstract selected as one of Top 4 Oral Abstracts at North American Forum on Family Planning
- 2013 Felicia Stewart Advocacy Award from the Population, Reproductive and Sexual Health Section of the American Public Health Association
- 2018 Outstanding Resident Teaching Award, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF
- 2019 Beacon of Science Award, Society of Family Planning

Key words/areas of interest

Abortion, medication abortion, second-trimester abortion, contraception, over-the-counter access to oral contraception, integration of family planning into HIV care and treatment, Latina reproductive health in the US, misoprostol and self-induction of abortion, Mexico, Peru, Bolivia, Dominican Republic, South Africa, Kenya

PROFESSIONAL ACTIVITIES**PROFESSIONAL ORGANIZATIONS**Memberships

- 2000-Present: Fellow, American College of Obstetrics and Gynecology (ACOG)
- 2006-Present: Fellow, Society of Family Planning
- 2004-Present: American Public Health Association
- 2013-Present: American Medical Association
- 2004-2011: Association of Reproductive Health Professionals
- 2004-2016: International Consortium for Medical Abortion
- 2006-Present: Liaison Member, Planned Parenthood Federation of America National Medical Committee
- 2005-Present: Consorcio Latinoamericano contra el Aborto Inseguro (Latin American Consortium against Unsafe Abortion)
- 2004-Present: Working Group on Oral Contraceptives Over-the-Counter

Service to professional organizations

- 2008-Present: Society of Family Planning, reviewer of grant proposals, abstract reviewer for annual meeting

2007-Present: American Public Health Association, Governing Councilor (2007-2009, 2010-2014), Section Secretary (2008-2009), abstract reviewer for annual meeting

2005-2012: Consorcio Latinoamericano contra el Aborto Inseguro, member of Coordinating Committee

2006-Present: Working Group on Oral Contraceptives Over-the-Counter, working group coordinator and member of steering committee

2010-2013: Member, Committee on Practice Bulletins-Gynecology, ACOG

2014-Present: Member, Committee on Health Care for Underserved Women, ACOG (Vice Chair of Committee 2016-18, Chair 2018-20)

2017-2018: Member, Telehealth Task Force, ACOG

2018-2019: Member, Telehealth Working Group, ACOG

2019: Member, Abortion Access and Training Expert Work Group, ACOG

2010-2016: Steering Committee member, International Consortium for Medical Abortion

2016: External advisor for Marie Stopes International research strategy meeting, March 23-24, 2016, London, UK

SERVICE TO PROFESSIONAL PUBLICATIONS

2013-Present: Editorial Board, Contraception

2004-Present: Ad hoc reviewer for Obstetrics and Gynecology (10 papers in past 5 years), American Journal of Public Health (4 papers in past 3 years), Reproductive Health Matters (6 articles in past 4 years), Expert Review of Obstetrics and Gynecology (3 review in past year), and Women's Health Issues (4 articles in past 2 years), Lancet (2 reviews in past year)

INVITED PRESENTATIONS (Selected)

International

Second-trimester abortion. Optimizing the Potential for Medication in Pregnancy Termination in South America Conference, Lima, Peru, 2014 (invited talk).

Participation in panel at Harvard University seminar: Politics, Public Health, and Abortion: Examining the Changing Legal Environment in Mexico and Central America, Cambridge, MA, 2014 (invited talk).

Evidence for removing the prescription barrier to hormonal contraception. Annual meeting of the Asociacion Française pour la Contraception, Paris, France, March 2015.

Presentations on medical abortion and second-trimester abortion, REDAAS (Red de Acceso al Aborto Seguro) meeting, Buenos Aires, Argentina, May 2015 (invited talk).

Panel participant in panel "Gestational limits for abortion: what purpose do they serve?" and presentations on adolescent pregnancy, telemedicine provision early medical abortion, and second-trimester abortion. Fifth Research Meeting on Unintended Pregnancy and Unsafe Abortion, Mexico City, September 2015 (invited talks).

Moving oral contraceptives over the counter as a strategy to reduce unintended pregnancy. The Human Right to Family Planning Conference, Seattle, WA, October 2015 (invited talk).

Over-the-counter access to hormonal contraception- what are the risks and benefits?, and Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. XXI FIGO World Congress of Gynecology and Obstetrics, Vancouver, Canada, October 2015 (oral presentations).

Second-trimester abortion. Presentation at the First Latin American Meeting on Public Sector Providers of Legal Abortion, Buenos Aires, Argentina, August 2016 (invited talk).
 Safety, effectiveness and acceptability of telemedicine provision of medication abortion in Iowa, NAF regional meeting, Mexico City, September 2017 (invited talk).
 Abortion in the United States: A new report on safety and the effects of being denied a wanted abortion. Presentation at “Evidencias y argumentos de salud pública para la legalización del aborto en Argentina,” Buenos Aires, Argentina, May 2018 (invited talk).
 Self-managed abortion in the United States. Presentation at “Abortion Beyond Bounds,” Montreal, Canada, October 2018.
 Gestational age limits in the United States: legal and service delivery perspectives. Presentation at “Interrupción del embarazo y edad gestacional,” Buenos Aires, Argentina, August 2019 (invited talk).

National

Participation in panel entitled Abortion Scholarship: An Interdisciplinary Conversation, at UC Berkeley Symposium Speech, Symbols, and Substantial Obstacles: The Doing and “Undue”ing of Abortion Law since Casey, Berkeley, 2013 (invited talk).
 Impact of restrictive abortion law on women in Texas. North American Forum on Family Planning, Seattle, 2013 (oral presentation).
 Randomized Trial of Misoprostol versus Laminaria before Dilation and Evacuation in South Africa. Annual meeting of the National Abortion Federation, San Francisco, 2014 (oral presentation).
 Introduction of the mifepristone regimen for second-trimester medical abortion in South Africa. Annual meeting of the National Abortion Federation, Baltimore, April 2015 (oral presentation).
 Knowledge, opinion and experience related to abortion self-induction in Texas (oral abstract), and participant in panel “Addressing the global need for safe abortion after the first trimester.” North American Forum on Family Planning, Chicago, November 2015 (oral presentations).
 Participant in panel “Addressing the Challenges Facing Women's Reproductive Health Care,” Academy Health National Health Policy Conference, Washington, DC, February 2, 2016 (invited talk).
 Panel presentations entitled “Medical abortion restrictions: From label laws to abortion reversal,” “Texas: Ground Zero in the Abortion Wars” and “Stolen Lives: Impact of early adolescent pregnancy on all aspects of health,” Annual meeting of the National Abortion Federation, Austin, Texas, April 2016.
 Panel presentations entitled “Evaluating Reproductive Health Policy at the State Level” and “Translating research into policy: Contributing data to the public debate when it matters most,” North American Forum on Family Planning, Denver, November 2016.
 Panel presentation entitled “Abortion Outside the Clinic: Imagining Safe and Legal Abortion in a post-Roe World,” Physicians for Reproductive Health Grand Rounds, New York University School of Law, New York, March 2017.
 “Safety of medication abortion provided through telemedicine: A non-inferiority study” (oral abstract), “Evaluating the provision of early medical abortion by telemedicine” (panel presentation), and “Use of research in evaluating Texas House Bill 2” (panel presentation). Annual meeting of the National Abortion Federation, Montreal, Canada, April 2017.

Using Evidence to Inform Policy in an Era of Alternative Facts, keynote address at Family Planning Symposium, “Family Planning Post-Election: Putting on our Fatigues,” San Diego, May 2017.

“Improving access through over-the-counter status” (panel presentation), “Building bridges, not walls: using telemedicine to expand sexual & reproductive healthcare” (panel presentation), and “Expanding access to medical abortion through clinic-to-clinic telemedicine” (panel presentation). North American Forum on Family Planning, Atlanta, October 2017.

“Prevalence of Self-Induced Abortion Attempts among a Nationally Representative Sample of U.S. Women” (oral abstract), “What do we know about self-induced or self-managed abortion in the United States?” (panel presentation). Annual meeting of the National Abortion Federation, Seattle, April 2018.

“Driving Health Equity Through Innovation in Health Care,” panel participant at plenary at the 2018 Planned Parenthood Federation of America National Conference, Washington, DC, April 2018.

Innovative Contraceptive Delivery Models. Presentation at National Reproductive Health Title X Conference, Kansas City, July 2018.

“Medication abortion in the United States” and panel participant in “The NASEM Report on Abortion Safety and Quality: implications for research, training, practice and advocacy.” North American Forum on Family Planning, New Orleans, October 2018.

Research on telemedicine and abortion care, panel presentation. Annual meeting of the National Abortion Federation, Chicago, May 2019.

Alternative provision models for medication abortion: from pharmacy dispensing to OTC. Annual meeting of the Mifepristone Coalition, New York City, June 2019.

“Medication abortion with pharmacist dispensing of mifepristone: a cohort study” (oral abstract), “‘It makes sense’: pharmacists’ attitudes toward dispensing mifepristone for medication abortion” (poster), “Abortion referral practices among a national sample of obstetrician-gynecologists” (poster). Annual meeting of Society of Family Planning, Los Angeles, October 2019.

Regional and other invited presentations

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, 2013.

Improving access to early medical abortion through the use of telemedicine. Office of Population Research seminar, Princeton University, 2014 (invited talk).

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Emory University School of Medicine, Atlanta, Georgia, February 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, Baylor University School of Medicine, Houston, Texas, April 2015.

The causes and consequences of unintended pregnancy among women in the US military. San Francisco General Hospital grand rounds, September 2015.

Impact of family planning cuts and abortion restrictions in Texas. Grand rounds presentation, Department of Obstetrics and Gynecology, University of New Mexico School of Medicine, Albuquerque, New Mexico, October 2015.

Using evidence and advocacy to improve second-trimester abortion care in South Africa. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, December 2015.

UCSF/UCH Consortium Annual Supreme Court Review, panel speaker on Whole Woman's Health v. Hellerstedt, San Francisco, July 2016.

American Gynecological Club meeting, presentation on Reproductive Health in Texas and panel participant, San Francisco, September 2016.

Speaking science to the Court: the experience of experts in Whole Woman's Health v. Hellerstedt, panel participant, UC Hastings, San Francisco, October 2016.

How data made the difference in the Texas abortion case before the US Supreme Court. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2016.

Research That Gets Results: A Symposium on Science-Driven Policy Change, panel participant, UCSF, March 2017.

Medication abortion: What is it and how can its potential to improve access to care be realized? Presentation for UCSF Students for Choice, April 2017.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2017.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, Kaiser San Francisco, March 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, University of Arizona College of Medicine, Tucson, June 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Presentation to Medical Students for Choice, University of Kansas Medical Center, July 2018.

Medication Abortion: Supporting Women Both Inside and Outside the Clinic to Access Safe Care. Grand rounds presentation, Department of Obstetrics and Gynecology, University of Alabama at Birmingham, October 2018.

Self-managed abortion in the US: What's happening, and what is our role? Grand rounds presentation, Department of Obstetrics, Gynecology and Reproductive Sciences, UCSF, November 2018.

Evidence-based advocacy to improve reproductive health. Annual Creinin Family Planning Lectureship, Department of Obstetrics, Gynecology & Reproductive Sciences, University of Pittsburgh, April 2019.

Evidence-based advocacy to improve reproductive health. Symposium speaker at the 2019 Research Retreat, Department of Obstetrics and Gynecology, University of Colorado, October 2019.

Demedicalizing reproductive health care: from OTC oral contraceptives to self-managed abortion. James C. and Joan Caillouette Lecture at the annual meeting of the Pacific Coast Obstetrical and Gynecological Society, San Diego, October 2019.

OTHER PROFESSIONAL SERVICE

2007	Member of the International Planned Parenthood Federation Safe Abortion Action Fund Technical Review Panel
2007-2009	Steering committee member of the California Microbicide Initiative

Daniel A. Grossman, M. D.

2002-2004 Member, Medical Development Team, Marie Stopes International (London)
 2013-Present: Reviewer of fellows' research proposals for the Fellowship in Family Planning
 2013-2015 Member of working group on Guidelines for Task Shifting in Abortion Provision convened by World Health Organization
 2014 Discovery working group member, Preterm Birth Initiative (PTBi), UCSF
 2013-2019 Board member and Secretary (2014-2016), NARAL Pro-Choice America Foundation (service completed September 26, 2019)
 2014-Present Board member, NAF
 2015-2019 Board member, Shift/Whole Woman's Health Alliance (service completed May 1, 2019)
 2017 Study section member, U54 Contraceptive Center proposal review panel, National Institute of Child Health and Human Development

TEACHING**FORMAL SCHEDULED CLASSES:**

Qtr	Academic Yr	Institution Course Title	Teaching Contribution	Class Size
W	2008-09	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 2 lectures	22
W	2009-10	Harvard School of Public Health; GHP502 International reproductive health issues: Moving from theory to practice	Lecturer; 1 lecture	17
F	2014-15	UCSF Coursera course; Abortion: Quality Care and Public Health Implications	Lecturer; 4 lectures	6,000+ (online)
F	2015-16	University of Texas at Austin; Sociology--Reproductive Health and Population in Texas; SS 301 Honors Social Science	Lecturer; 1 lecture	20
S	2016-17	UC Berkeley School of Law; 224.6 - Selected Topics in Reproductive Justice	Lecturer; 1 lecture	12
S	2018-19	University of Texas at Austin; Sociology—Graduate seminar in human fertility	Lecturer; 1 seminar	8

POSTGRADUATE and OTHER COURSES

Guest lecturer in "Qualitative Research Methods in Public Health," CUNY School of Public Health, September 2011

Women's health from a global perspective. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2007.
 Expanding access to medication abortion. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2017.
 A world post Roe v. Wade. Presentation at Obstetrics and Gynecology Update: What Does the Evidence Tell Us? UCSF CME course, San Francisco, 2019.

TEACHING AIDS

Contributed to the development of a training slide set on medical abortion in Spanish, 2004
 Developed pocket cards on emergency contraception for use by community health workers in the State of Mexico, 2005
 Reviewed and provided input on a manual on gynecologic uses of misoprostol published by the Latin American Federation of Obstetric and Gynecologic Societies (FLASOG), 2005
 Grossman D. Medical methods for first trimester abortion: RHL commentary (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005. Exerpt available at:
<http://www.rhlibrary.com/Commentaries/htm/Dgcom.htm>.
 Grossman D. Medical methods for first trimester abortion: RHL practical aspects (last revised: 3 September 2004). The WHO Reproductive Health Library, No 8, Update Software Ltd, Oxford, 2005.

RESEARCH AND CREATIVE ACTIVITIES

PEER REVIEWED PUBLICATIONS

1. Laudon M, Grossman DA, Ben-Jonathan N. Prolactin-releasing factor: cellular origin in the intermediate lobe of the pituitary. *Endocrinology* 1990; 126(6):3185-92.
2. Grossman DA, Witham ND, Burr DH, Lesmana M, Rubin FA, Schoolnik GK, Parsonnet J. Flagellar serotypes of *Salmonella typhi* in Indonesia: relationships among motility, invasiveness, and clinical illness. *Journal of Infectious Diseases* 1995; 171(1):212-6.
3. MacIsaac L, Grossman D, Balistreri E, Darney P. A randomized controlled trial of laminaria, oral misoprostol, and vaginal misoprostol before abortion. *Obstetrics and Gynecology* 1999; 93(5, pt.1):766-770.
4. Grossman D, Ellertson C, Grimes DA, Walker D. Routine follow-up visits after first-trimester induced abortion. *Obstetrics and Gynecology* 2004; 103(4):738-45.
5. Lafaurie MM, Grossman D, Troncoso E, Billings DL, Chávez S. Women's perspectives on medical abortion in Mexico, Colombia, Ecuador and Peru: a qualitative study. *Reproductive Health Matters* 2005;13(26):75-83.
6. Grossman D, Ellertson C, Abuabara K, Blanchard K. Barriers to contraceptive use present in product labeling and practice guidelines. *American Journal Public Health* 2006;96(5):791-9.
7. Yeatman SE, Potter JE, Grossman DA. Over-the-counter access, changing WHO guidelines, and the prevalence of contraindicated oral contraceptive use in Mexico. *Studies in Family Planning* 2006; 37(3):197-204.

8. Pace L, Grossman D, Chavez S, Távora L, Lara D, Guerrero R. Legal Abortion in Peru: Knowledge, attitudes and practices among a group of physician leaders. *Gaceta Medica de Mexico* 2006; 142(Supplement 2):91-5.
9. Lara D, Abuabara K, Grossman D, Diaz C. Pharmacy provision of medical abortifacients in a Latin American city. *Contraception* 2006;74(5):394-9.
10. Tinajeros F, Grossman D, Richmond K, Steele M, Garcia SG, Zegarra L, Revollo R. Diagnostic accuracy of a point-of-care syphilis test when used among pregnant women in Bolivia. *Sexually Transmitted Infections* 2006;82 Suppl 5:v17-21.
11. Clark W, Gold M, Grossman D, Winikoff B. Can mifepristone medical abortion be simplified? A review of the evidence and questions for future research. *Contraception* 2007;75:245-50.
12. Garcia SG, Tinajeros F, Revollo R, Yam EA, Richmond K, Díaz-Olavarrieta C, Grossman D. Demonstrating public health at work: A demonstration project of congenital syphilis prevention efforts in Bolivia. *Sexually Transmitted Diseases* 2007;34(7):S37-S41.
13. Díaz-Olavarrieta C, García SG, Feldman BS, Polis AM, Revollo R, Tinajeros F, Grossman D. Maternal syphilis and intimate partner violence in Bolivia: a gender-based analysis of implications for partner notification and universal screening. *Sex Transm Dis* 2007;34(7 Suppl):S42-6.
14. Harper CC, Blanchard K, Grossman D, Henderson J, Darney P. Reducing Maternal Mortality due to Abortion: Potential Impact of Misoprostol in Low-resource Settings. *International Journal of Gynecology and Obstetrics* 2007;98:66-9.
15. Grossman D, Berdichevsky K, Larrea F, Beltran J. Accuracy of a semi-quantitative urine pregnancy test compared to serum beta-hCG measurement: a possible tool to rule-out ongoing pregnancy after medication abortion. *Contraception* 2007;76(2):101-4.
16. Lara D, van Dijk M, Garcia S, Grossman D. La introducción de la anticoncepción de emergencia en la norma oficial mexicana de planificación familiar (The introduction of emergency contraception into the official Mexican family planning norms). *Gaceta Médica de México* 2007;143(6): 483-7.
17. Grossman D, Blanchard K, Blumenthal P. Complications after second trimester surgical and medical abortion. *Reproductive Health Matters* 2008;16(31 Supplement):173-82.
18. Grossman D, Fernandez L, Hopkins K, Amastae J, Garcia SG, Potter JE. Accuracy of self-screening for contraindications to combined oral contraceptive use. *Obstetrics and Gynecology* 2008; 112(3):572-8.
19. Grossman D. Should the oral contraceptive pill be available without prescription? Yes. *British Medical Journal* 2008;337:a3044.
20. Levin C, Grossman D, Berdichevsky K, Diaz C, Aracena B, Garcia S, Goodyear L. Exploring the economic consequences of unsafe abortion: implications for the costs of service provision in Mexico City. *Reproductive Health Matters* 2009;17(33):120–132.
21. Hu D, Grossman D, Levin C, Blanchard K, Goldie SJ. Cost-Effectiveness Analysis of Alternative First-Trimester Pregnancy Termination Strategies in Mexico City. *BJOG* 2009;116:768–779.
22. Távora-Orozco L, Chávez S, Grossman D, Lara D, Blandón MM. Disponibilidad y uso obstétrico del misoprostol en los países de América [Availability and obstetric

- use of misoprostol in Latin American countries]. *Revista Peruana de Ginecologia y Obstetricia* 2009;54:253-263.
23. Lara DK, Grossman D, Muñoz J, Rosario S, Gomez B, Garcia SG. Acceptability and use of female condom and diaphragm among sex workers in Dominican Republic: Results from a prospective study. *AIDS Education and Prevention* 2009;21(6):538-551.
 24. Grossman D, Fernandez L, Hopkins K, Amastae J, Potter JE. Perceptions of the safety of oral contraceptives among a predominantly Latina population in Texas. *Contraception* 2010;81(3):254-60. (NIHMS155993)
 25. Potter JE, White K, Hopkins K, Amastae J, Grossman D. Clinic versus Over-the-Counter Access to Oral Contraception: Choices Women Make in El Paso, Texas. *American Journal of Public Health* 2010;100(6):1130-6. (NIHMS 221745)
 26. Phillips K, Grossman D, Weitz T, Trussell J. Bringing evidence to the debate on abortion coverage in health reform legislation: findings from a national survey in the United States. *Contraception* 2010;82(2):129-30.
 27. Hu D, Grossman D, Levin C, Blanchard K, Adanu R, Goldie SJ. Cost-Effectiveness Analysis of Unsafe Abortion and Alternative First-Trimester Pregnancy Termination Strategies in Nigeria and Ghana. *African Journal of Reproductive Health* 2010;14(2):85-103.
 28. Grossman D, Holt K, Peña M, Veatch M, Gold M, Winikoff B, Blanchard K. Self-induction of abortion among women in the United States. *Reproductive Health Matters* 2010;18(36):136-146.
 29. Grossman D, Grindlay K. Alternatives to ultrasound for follow-up after medication abortion: A systematic review. *Contraception* 2011;83(6):504-10.
 30. Liang S-Y, Grossman D, Phillips K. Women's out-of-pocket expenditures and dispensing patterns for oral contraceptive pills between 1996 and 2006. *Contraception* 2011;83(6):528-36.
 31. Blanchard K, Bostrom A, Montgomery E, van der Straten A, Lince N, de Bruyn G, Grossman D, Chipato T, Ranjee G, Padian N. Contraception use and effectiveness among women in a trial of the diaphragm for HIV prevention. *Contraception* 2011;83(6):556-63.
 32. Grossman D, White K, Hopkins K, Amastae J, Shedlin M, Potter JE. Contraindications to Combined Oral Contraceptives Among Over-the-Counter versus Prescription Users. *Obstet Gynecol* 2011;117(3):558-65.
 33. Potter JE, McKinnon S, Hopkins K, Amastae J, Shedlin MG, Powers DA, Grossman D. Continuation of prescribed compared with over-the-counter oral contraceptives. *Obstet Gynecol* 2011;117(3):551-7.
 34. Grindlay K, Yanow S, Jelinska K, Gomperts R, Grossman D. Abortion restrictions in the US military: Voices from women deployed overseas. *Women's Health Issues* 2011;21(4):259-64.
 35. Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and Acceptability of Medical Abortion Provided Through Telemedicine. *Obstetrics and Gynecology* 2011;118(2 Pt 1):296-303.
 36. Holt K, Grindlay K, Taskier M, Grossman D. Unintended pregnancy and contraceptive use among women in the US military: A systematic literature review. *Military Medicine* 2011;176(9):1056-64.
 37. Harris LH, Grossman D. Confronting the challenge of unsafe second-trimester abortion. *Int J Gynaecol Obstet* 2011;115(1):77-9.

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LANGUAGES

Fluent in Spanish, conversant in French.